No. 2B
-21-40
X22659
A21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7963

Registration District No. 257 Primary Registration District No. 5998 Registrar's No. 48

1. PLACE OF DEATH:
(a) County ST. CHARLES COUNTY, MISSOURI
(b) City or town ST. CHARLES
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: EVANGELICAL EMMAUS HOME 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 yrs. 7 mos. 21 Das. (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County ST. LOUIS
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME MRS. LILLIAN WERNER 656

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife ARTHUR WERNER
6. (c) Age of husband or wife if alive years
7. Birth date of deceased JUNE 7 1893
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	46	8	22	hr. min.

9. Birthplace GERMANY
(City, town, or county) (State or foreign country)
10. Usual occupation HOUSE WORK
11. Industry or business
FATHER 12. Name ADOLPH BAHLKOW
13. Birthplace GERMANY
(City, town, or county) (State or foreign country)
MOTHER 14. Maiden name IDA SCHOLTZ
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)
16. (a) Informant Theophil Stoerker
(b) Address St. Charles, Mo.
17. (a) Burial (Burial, cremation, or removal)
(b) Date thereof Mar 2 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Burial Park
18. (a) Signature of funeral director A. Kron L & U. Co
(b) Address 2707 N Grand Blvd
19. (a) 3/1/40 (Date received local registrar)
(b) Clarence G. Nessler (Registrar's signature)
170
611

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb, day 29th
year 1940 hour 12 minute 10 A.M.
21. I hereby certify that I attended the deceased from Jan 15th, 1940 to Feb 29th, 1940
that I last saw her alive on Feb 25th, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Congestion of Lungs	6 hrs.
Due to Post Encephalitis	1½ Mo.
Due to La Grippe	7 da.
Other conditions Hydrocephalus (Include pregnancy within 3 months of death)	
Major findings: Of operations None	
Of autopsy None	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature A. P. Emil Schunke (M.D. or other)
Address St. Charles Mo. Date signed 2/29/40

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by_____

_____, Registered Apprentice No._____

working under my personal supervision.

Signed_____

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7963

Registration District No. 757   Primary Registration District No. 5998   Registrar's No. 48

1. PLACE OF DEATH:
(a) County St Charles
(b) ~~City or town~~ St Charles rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution .... In this community .... (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State .... (b) County ....
(c) City or town .... (If outside city or town limits write "RURAL")
(d) Street No. .... (If rural, give location)
(e) If foreign born, how long in U. S. A.? .... years.

3. (a) Print Full Name Mrs Lillian Werner
3. (b) If veteran, name war .... 3. (c) Social Security No. ....
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife ....
6. (c) Age of husband, or wife, if alive .... years
7. Birth date of deceased .... (Month) (Day) (Year)
8. AGE: Years 46 Months 8 Days 12 If less than one day .... hr. .... min.
9. Birthplace .... (City, town, or county) (State or foreign country)
10. Usual occupation ....
11. Industry or business ....
FATHER
12. Name ....
13. Birthplace .... (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name ....
15. Birthplace .... (City, town, or county) (State or foreign country)
16. (a) Informant ....
(b) Address ....
17. (a) .... (Burial, cremation, or removal) (b) Date thereof .... (Month) (Day) (Year)
(c) Place: burial or cremation ....
18. (a) Signature of funeral director ....
(b) Address ....
19. (a) .... (Date received local registrar) (b) .... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 29 year 1940 hour .... minute .... M.
21. I hereby certify that I attended the deceased from ...., 19...., to ...., 19....;
that I last saw h.... alive on ...., 19....,
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Congestion of ~~Lungs~~	6 hrs
Post Encephalitis Lung	1 1/2 mo
Due to La Grippe	7 da
Due to	
Other conditions Hydrocephalous (Congenital) (Include pregnancy within 3 months of death)	

Major findings:
Of operations ....
Of autopsy ....

PHYSICIAN Underline the cause to which death should be charged statistically.

11B1

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ....
(b) Date of occurrence ....
(c) Where did injury occur? .... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? .... (Specify type of place)
While at work? .... (e) Means of injury ....
23. Signature A. P. Emrich Schulz (M.D. or other)
Address St Charles   Date signed ....

SUPPLEMENTARY